

3 Health Care Providers of the Healing Arts Program Guidelines Contents

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3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by health care providers of the healing arts as deemed appropriate by Medicaid. It addresses the following:

- Claims payment
- Prior authorization
- Covered/non-covered services for:
 - chiropractors
 - dieticians
 - physical therapists
 - podiatrists
 - radiology technicians
 - social workers
- Electronic and paper claims billing

3.1.2 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS-1500 claim form or in the appropriate field when billing electronically. Not all provider types in this manual are eligible to provide services in all settings. Idaho Medicaid follows the national place-of-service codes found in the national CPT (current procedural terminology) codebook.

3.2 Chiropractic Service Policy

3.2.1 Overview

Medicaid pays for a total of twenty-four (24) spinal manipulations during any calendar year for remedial chiropractic care. Chiropractic services are limited to the manual manipulation of the spine to correct a subluxation condition.

Any claim with an injury-related diagnosis code must include the cause of the injury, and when and where the injury occurred. Enter this information in field 19 of the CMS-1500 claim form. This information may be included in the narrative field when billing electronically.

3.2.2 Prior Authorization

Prior authorization is not required for chiropractic services.

3.2.3 Covered Services

Medicaid only reimburses for treatment involving manipulation of the spine to correct a subluxation condition. Medicaid does not reimburse for any other chiropractic services.

3.2.4 Diagnosis Code

Use only the ICD-9-CM code **839** (with fifth-digit subclassification) on all chiropractic claims for covered services provided to Medicaid participants.

3.2.5 Modifiers

Modifiers are not required for chiropractic services.

3.2.6 Procedure Codes

Covered chiropractic services must be billed using the accepted CPT codes in the table:

| CPT Code | Description |
|----------|---|
| 98940 | Chiropractic manipulative treatment (CMT); spinal, one to two regions. |
| 98941 | Chiropractic manipulative treatment (CMT); spinal, three to four regions. |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, five regions. |

3.2.7 Payment

Chiropractors are paid on a fee-for-service basis. The maximum fee paid is based upon Medicaid's fee schedule.

3.2.8 Healthy Connections

Medicaid participants enrolled in Healthy Connections, Idaho's Primary Care Case Management (PCCM) model of managed care., may obtain services without a referral when those services or procedures are performed in a chiropractor's office.

Note:
Chiropractic services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.3 Dietician Service Policy

3.3.1 Overview

Dietitians may bill the Medicaid program directly for nutritional services provided to pregnant women. Nutritional services include intensive nutritional education, counseling, and monitoring. Either a registered dietitian must render these services **or** an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. If a dietitian works for a hospital, the hospital bills Medicaid directly for the services.

Note: Dietician services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.3.2 Covered Services

3.3.2.1 PW Nutritional Services

Nutritional services for women enrolled in the PW (Pregnant Women) program. All criteria listed must be met:

- Must be ordered by the participant's physician, nurse practitioner or nurse midwife
- Must be delivered after confirmation of pregnancy
- Extend only through the 60th day after delivery

3.3.2.2 EPSDT Nutritional Services

EPSDT benefits are for children through the month of their twenty-first (21) birthday. All criteria listed must be met:

- Must be discovered by an EPSDT screen
- Ordered by a physician
- Determined to be medically necessary
- Determined to not be due to obesity
- Must be billed with diagnosis **V20.1** Other Healthy Infant/Child or **V20.2** Routine Infant or Child Health Check

Note
If a dietitian works for a hospital, then the hospital bills directly for this service.

3.3.3 Limitations

3.3.3.1 PW

Payment for two (2) visits during the covered period is available at a rate established by the Department under provisions of Subsection 03.09.060.04.

3.3.3.2 Early Periodic Screening Diagnosis and Treatment (EPSDT)

Payment for two (2) visits during the calendar year is available at a rate established under the provisions of Subsection 03.09.060.04.

Children may receive two (2) additional visits when prior authorized by the EPSDT Coordinator. Submit prior authorization requests to:

Idaho Medicaid
Bureau of Medical Care
Attn: EPSDT Coordinator
P.O. Box 83720
Boise, Idaho 83720-0036

Requests can also be faxed to (208) 332-7280, Attn: EPSDT Coordinator, Bureau of Medical Care. For questions regarding EPSDT prior authorizations, contact the EPSDT Coordinator (208) 364-1842.

3.3.4 Procedure Codes

| Service | Code | Modifier | Description |
|----------------------------|-------|----------------------|--|
| PW Nutritional Services | S9470 | U5 | Nutritional Counseling, dietician visit <i>The U5 (PW) modifier is required when reporting dietician services for PW</i> |
| EPSDT Nutritional Services | S9470 | No modifier required | Nutritional Counseling, dietician visit |

3.4 Physical Therapy Service Policy

3.4.1 Overview

Medicaid covers physician-ordered physical therapy rendered by a licensed physical therapist, as defined in Idaho Administrative Code, IDAPA 22.01.05, in the participant's home or in the therapist's office.

Medicaid will cover twenty-five (25) physical therapy outpatient visits per participant during any calendar year (January through December) regardless of the billing provider. Visits exceeding the 25-visit limitation must be prior authorized before services are rendered.

3.4.2 Physician Orders

Physical therapy treatments must have a written physician's order and be a part of a plan of care. The participant's progress must be reviewed and the plan of care updated and reordered every 30 days by a physician, unless the therapist has documentation from the physician indicating that a chronic condition exists that will require therapy for more than 6 months. In these cases, a physician order for continued care is required at least every 6 months.

The plan of care or written physician's order must stipulate the type of physical therapy needed, the frequency of treatment, expected duration of therapy, anticipated outcomes, and the physician's signature and date. The provider must maintain a copy of the plan of care or written physician's order in the participant's file.

3.4.3 Independent Therapist

Physical therapy services must be rendered by a Medicaid qualified independent therapist. A therapist who treats participants in a nursing home or hospital, inpatient or outpatient, home health agency, developmental disability center, or school system is not considered an independent therapist and such services must be billed by that entity.

3.4.4 Payment

Physical therapists are paid on a fee-for-service basis. The maximum fee paid is based upon Medicaid's fee schedule.

3.4.5 Healthy Connections

Check eligibility to see if the participant is enrolled in Healthy Connections, Idaho's Primary Care Case Management (PCCM) model of managed care. If a participant is enrolled, a referral is required from the Healthy Connections Primary Care Provider (PCP) before services can be rendered.

3.4.6 Post-payment Review

The plan of care is not required as an attachment to physical therapy claims when submitted to Medicaid. The plan of care and documentation of services rendered must be maintained by the provider. A random sample of claims will be selected for post-payment review.

When a claim is selected for review, the provider will be notified in writing by EDS and required to provide the appropriate documentation to substantiate the Medicaid payment. Medicaid will recoup the payment if proper documentation cannot be produced by the provider.

Note: Physical Therapy services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

See **Section 1.5** for more information on the Healthy Connections guidelines.

3.4.7 Prior Authorization (PA)/Procedure Codes

The Department must authorize physical therapy services over 25 visits in a calendar year. If prior authorization (PA) is required, the PA number must be indicated on the claim, or the service will be denied.

PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated. The following CPT procedure codes must have PA even if the 25-visit limitation has not been met:

97039 Unlisted modality (specify type and time if constant attendance)

97139 Unlisted therapeutic procedure (specify)

97799 Unlisted physical medicine/rehabilitation service or procedure (specify)

The Bureau of Care Management is responsible for the PA of the above codes and visits in excess of 25 per calendar year. Write or fax PA requests for these codes to:

Idaho Medicaid
Bureau of Medical Care
P.O. Box 83720
Boise, ID 83720-0036

FAX: (208) 332-7280
Phone: (208) 364-1842

Medicaid reimburses for physical therapy as an extended state plan service under the waiver for adults with a traumatic brain injury (TBI). To be eligible for services under the TBI Waiver program, the participant must be enrolled in the Medicaid Enhanced Plan Benefits. In addition Regional Medicaid Services (RMS) must PA all services reimbursed by Medicaid under the TBI Waiver program prior to services being rendered. See the Directory for information regarding where to send RMS PA requests.

For Healthy Connections participants, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

3.4.8 Covered Services

3.4.8.1 Overview

Idaho Medicaid defines covered physical therapy modalities, treatments, and testing as described in the Current Procedural Terminology (CPT) by procedure codes.

3.4.8.2 Modalities

A modality is any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

3.4.8.3 Therapeutic Procedures

Therapeutic procedures are the application of clinical skills and/or services that attempt to improve function. All therapeutic procedures require the therapist to have direct, one-on-one participant contact. Therapeutic procedures include therapeutic exercises, neuromuscular re-education,

See **Section 2.3.2** for more information on billing services that require Prior Authorization.

aquatic therapy with therapeutic exercises, gait training, manual therapy techniques, orthotics and prosthetics training, therapeutic activities, self-care training, and propulsion training.

3.4.9 Additional Tests or Measurements

Tests or measurements as described by CPT procedure codes 97762 and 97750 may be reimbursed. The physical therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in CPT procedure codes 95831 through 95904 when ordered by a physician.

3.4.10 Excluded Services

Services excluded from Medicaid program coverage include group exercise therapy, group hydrotherapy, acupuncture (with or without electrical stimulation), and biofeedback services.

3.5 Podiatry Service Policy

3.5.1 Overview

Medicaid covers podiatry services rendered for the treatment of acute foot conditions. Acute foot conditions are defined as any condition that hinders normal function, threatens the individual, or complicates any disease. However, preventive foot care may be provided in the presence of vascular restrictions or other systemic diseases.

3.5.2 Service Limitations

The following podiatry services are covered only under specific conditions:

- Care of the foot and ankle — limited to the area from the midcalf down
- Orthotics — only if prior authorized by Medicaid
- Muscle testing and range of motion studies — only if billed separately from outpatient visits for evaluation and management. Medicaid considers these services part of a routine office visit
- Surgical removal of corns and calluses — only when there is systemic disease present
- Cutting, removal, debridement or other surgical treatment of toenails — only when there is an acute condition or systemic disease present

3.5.3 Non-covered Services

The following podiatry services are generally not covered:

- Daily care in an inpatient hospital setting (reviewed on a case-by-case basis)
- Daily inpatient care in a skilled nursing facility, intermediate care facility, or long term care facility (the podiatrist is not the attending physician in this setting)

3.5.4 Payment

Podiatrists are paid on a fee-for-service basis. The maximum fee paid is based upon Medicaid's fee schedule.

3.5.5 Prior Authorization (PA)

Prior authorization (PA) is not required for podiatrist procedures, except for orthotics. If PA is required, the PA number must be indicated on the claim form or the service will be denied.

3.5.6 Procedure Codes

All claims must use the appropriate five-digit CPT procedure codes and if applicable, modifiers. Refer to the CPT (Current Procedural Terminology) manual for the appropriate codes.

3.5.7 Diagnosis Code

All claims must list the appropriate ICD-9-CM diagnosis code for acute conditions. The acute condition must be indicated on the initial claim and all subsequent claims.

Note: Podiatry services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

See **Section 2.3.2** for more information on billing services that require Prior Authorization.

3.5.8 Healthy Connections (HC)

Medicaid participants enrolled in Healthy Connections (HC), Idaho's Primary Care Case Management (PCCM) model of managed care, may obtain services without a referral if those services/procedures are performed in a podiatrist's office.

However, procedures that are performed in an inpatient or outpatient hospital or ambulatory surgery center setting require a referral from the primary care provider for the facility and the ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative examination by a physician, and lab work.

3.6 Radiology Technician Service Policy

3.6.1 Overview

Radiology services have both a technical and professional component. Radiology Technicians can have their own provider number and bill for the technical component if they own, rent or lease the equipment used for the radiology service. If the radiology technician does not own, rent or lease the equipment, the technical component is billed by the physician, clinic, or facility owning the equipment.

3.6.2 Covered Services

The technical component includes charges for the following:

- Personnel
- Material, including usual contrast media and drugs
- Film or xerograph
- Space, equipment, and other facility charges

The technical component does **not** include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. To be assured of adequate reimbursement, attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs to providers and the radioisotopes billed, this information is necessary to adequately price each claim.

3.6.3 Modifiers

To identify a charge for the technical component use the appropriate five-digit CPT procedure code with the **TC** modifier.

3.6.4 Mobile Imaging Units

If the Radiology technician owns, leases, or rents the mobile radiology equipment, he/she must:

- Be enrolled as a provider type and specialty 023/218 (healing arts provider type, radiology technical services specialty).
- Provide proof of ownership, or lease or rental agreements for this provider type.
- Providers billing for services in a mobile imaging unit must bill with place of service **15** – Mobile Unit.

3.6.5 Procedure Codes

Idaho Medicaid uses CPT codes found in the current version of the American Medical Association CPT book under Diagnostic Radiology (Diagnostic Imaging 70010-76499).

3.6.6 Payment

Only bill for the technical component of radiology. Payment is at a rate established under the provisions of IDAPA 16.03.09.060.04 of the Medical Assistance Rules.

Note:
Radiology Technician services **are** covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.7 Social Work

3.7.1 Overview

Social workers are only paid directly for providing physician-ordered pregnancy related services. Individual and family social services, limited to two (2) visits during the covered period, are allowed when directed at helping a participant to overcome social or behavioral problems which may adversely affect the outcome of the pregnancy. Services to assist the participant in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome are also allowed.

3.7.2 Payment

Payment is available to licensed social workers either in independent practice or as employees of entities that have current provider agreements with the Department. Payment is at a rate established under the provisions of IDAPA 16.03.09.060.04 of the Medical Assistance Rules.

Service is limited to two (2) visits during the covered period by a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners.

3.7.3 Procedure Codes

| HCPCS Code | Modifier | Description |
|------------|---------------------------|---|
| S9127 | U5 (PW program) | Social work visit, in the home, per diem (Individual and family social services) <i>Modifier U5 is required</i> |

Note: Social Work services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.8 Claim Billing

3.8.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.8.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.8.2.1 Guidelines for Electronic Claims

Detail lines

Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number

A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring provider's Medicaid provider number, unless the participant is a Healthy Connections participant. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers

Idaho Medicaid allows more than one PA number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers

Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes

Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers

Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.8.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

See **Section 2** for more information on electronic billing.

3.8.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.8.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.8.3.3 Completing Specific Fields

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

| Field | Field Name | Use | Directions |
|-------|--|-------------------------|--|
| 1a | Patient ID | Required | Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card. |
| 2 | Patient's Name | Required | Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial. |
| 9a | Other Insured's Policy or Group Number | Required if applicable. | Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number. |

| Field | Field Name | Use | Directions |
|----------|---|-------------------------|--|
| 9b | Other Insured's Date of Birth/Sex | Required if applicable. | Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex. |
| 9c | Employer's Name or School Name | Required if applicable. | Required if field 11d is marked YES. |
| 9d | Insurance Plan Name or Program Name | Required if applicable. | Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name. |
| 10a | Is Condition Related to Employment? | Required | Indicate yes or no if this condition is related to the participant's employment. |
| 10b | Auto Accident? | Required | Indicate yes or no if this condition is related to an auto accident. |
| 10c | Other Accident? | Required | Indicate yes or no if this condition is related to an accident. |
| 11d | Is There Another Health Benefit Plan? | Required | Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d. |
| 14 | Date of Current: Illness, Injury or Pregnancy | Desired | Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy. |
| 15 | If Patient Has Had Same or Similar Illness | Desired | If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit. |
| 17 | Name of Referring Physician or Other Source | Required if applicable. | Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name. |
| 17a | ID Number of Referring Physician | Required if applicable | Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number. |
| 19 | Reserved for Local Use | Required if applicable | If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing. |
| 21 (1-4) | Diagnosis or Nature of Illness or Injury | Required | Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis. |
| 23 | Prior Authorization Number | Required | If applicable, enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU. |
| 24A | Date of Service — From/To | Required | Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2005 becomes 11242005 with no spaces and no slashes. |
| 24B | Place of Service | Required | Enter the appropriate numeric code in the place of service box on the claim. |

| Field | Field Name | Use | Directions |
|-------|-----------------------------|------------------------|---|
| 24D 1 | Procedure Code Number | Required | Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided. |
| 24D 2 | Modifier | Required if applicable | If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank. |
| 24E | Diagnosis Code | Required | Use the number of the subfield (1-4) for the diagnosis code entered in field 21. |
| 24F | Charges | Required | Enter your usual and customary fee for each line item or service. Do not include tax. |
| 24G | Days or Units | Required | Enter the quantity or number of units of the service provided. |
| 24H1 | EPSDT (Health Check) Screen | Required if applicable | Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook. |
| 24I | EMG | Required if applicable | If the services performed are related to an emergency, mark this field with an X . |
| 24K | Reserved for Local Use | Required if applicable | When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33. |
| 28 | Total Charge | Required | Add the charges for each line then enter the total amount. |
| 29 | Amount Paid | Required | Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim including the explanation for the denial reason. |
| 30 | Balance Due | Required | Enter the total charges, less amount entered in amount paid field. |
| 31 | Signature and Date | Required | The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information. |
| 33 | Provider Name and Address | Required | Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated. |
| 33 | GRP — Provider Number | Required | Enter your nine-digit Medicaid provider number. |

3.8.3.4 Sample Paper Claim Form

PLEASE
DO NOT
STAPLE
IN THIS
AREA

| PICA | | | | | | | | | | PICA | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY M SEX F | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | |
| CITY STATE | | | | | | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | | | | | |
| ZIP CODE TELEPHONE (Include Area Code) | | | | | | | | | | CITY STATE | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | | | | | | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | |
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | | | | | | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. | | | | | | | | | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | |
| 1. 2. 3. 4. | | | | | | | | | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 24. A B C D E F G H I J K DATE(S) OF SERVICE To Place of Type of PROCEDURES, SERVICES, OR SUPPLIES DIAGNOSIS CODE \$ CHARGES DAYS OR EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE From MM DD YY Service Service (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 1. 2. 3. 4. 5. 6. | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.) | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | | | | | | | | | | 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ \$ \$ | | | | | | | | | |
| 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # | | | | | | | | | | PIN# GRP# | | | | | | | | | |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500